Complete Summary

GUIDELINE TITLE

Diagnosis and classification of primary headache disorders. In: Standards of care for headache diagnosis and treatment.

BIBLIOGRAPHIC SOURCE(S)

Martin V, Elkind A. Diagnosis and classification of primary headache disorders. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache Foundation; 2004. p. 4-18. [35 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Primary headaches including:

- Migraine (with or without aura)
- Tension-type headache (TTH)
- Cluster headache
- Chronic daily headache (CDH)
- Chronic tension-type headache (CTTH)
- New daily persistent headache
- Hemicrania continua

GUIDELINE CATEGORY

Diagnosis

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Neurology

INTENDED USERS

Health Care Providers
Physicians

GUIDELINE OBJECTIVE(S)

- To improve the medical treatment of headache
- To review standard taxonomy for classifying headache
- To outline a rational approach to headache diagnosis in clinical practice
- To help physicians and other health care professionals to:
    - Rule out secondary headache and establish a primary headache diagnosis
    - Recognize indications for appropriate and timely referrals to specialists

TARGET POPULATION

Patients with primary headache disorders

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Classification of headaches according to the International Headache Society (IHS) classification scheme
2. Physical examination and recording of patient history
3. Laboratory studies
    - Hepatic profile
    - Appropriate endocrinologic tests as necessary
    - Erythrocyte sedimentation rate (in patients over the age of 50)
4. Neuroimaging
    - Computed tomography (CT)
    - Magnetic resonance imaging/angiography (MRI/MRA)
5. Lumbar puncture
6. Electroencephalography (rarely necessary)
7. Thermography (considered, but not recommended)
8. Transcranial Doppler studies (considered, but not recommended)
9. Specialist referral

MAJOR OUTCOMES CONSIDERED

- Sensitivity and specificity of diagnostic tests
- Predictive value of diagnostic tests

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guidelines presented in this monograph represent the consensus of an advisory panel of practitioners chosen by the National Headache Foundation (NHF) for their expertise. In addition to incorporating the US Headache Consortium's recommendations, their conclusions reflect clinical experience and the most recent medical literature.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not applicable

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Diagnosis and Classification of Primary Headache Disorders

The ability to make a rapid and accurate diagnosis is crucial to the successful management of any headache disorder. Since head pain can have many causes, a rational approach will facilitate differential diagnosis and may increase the likelihood of a positive therapeutic outcome. This chapter reviews standard taxonomy for classifying headache and outlines a rational approach to headache diagnosis in clinical practice.

Classification of Headache

Headache disorders are generally classified as either primary or secondary, and these classifications are further divided into specific headache types. The primary headache disorders - those not associated with an underlying pathology - include migraine, tension-type, and cluster headache. Secondary headache disorders - those attributed to an underlying pathologic condition - include any head pain of infectious, neoplastic, vascular, drug-induced, or idiopathic origin (see table 1.1 of the original guideline document). The vast majority of patients who present with headache have one of the primary disorders, as serious secondary causes for presentation with head pain are rare.

A number of diagnostic schemata for headache have been proposed. As early as 1962, for example, the Ad Hoc Committee on Classification of Headache listed the features that are typically present during certain types of headache, but it failed to indicate which features or combinations of features were required to establish a diagnosis. By 1988, recognizing the need for improvement in headache classification, the International Headache Society (IHS) published a new system. The updated IHS criteria outline the specific characteristics necessary to confirm a broad range of headache disorders.

Please refer to the original guideline document for a discussion of the history of headache classification schemes up to and including the International Headache Society's current criteria.

Types of Primary Headache

Migraine

Migraine is a chronic neurologic disorder characterized by episodic attacks of head pain and associated symptoms. Methodologically identical epidemiologic studies conducted 10 years apart show that the prevalence and distribution of migraine have remained stable over the last decade in the United States, with about 18% of women and 6% of men satisfying diagnostic criteria for the condition. Studies done outside the United States show an agreement in overall migraine prevalence rates. For example, in data from the Netherlands, the 1-year prevalence of migraine in adults is estimated at 10 to 12% in men and 15 to 18% in women. Even though it is widespread, migraine remains underdiagnosed; only 48% of Americans who satisfy criteria for migraine reported receiving a physician diagnosis of migraine.

With Aura

The IHS recognizes 6 variants of migraine, but the most common types seen in primary care practice are migraine with aura (formerly "classic" migraine), migraine without aura (formerly "common" migraine), and probable migraine, formerly called migrainous headache. Providers should suspect migraine with aura whenever a headache is preceded by one of the following neurologic symptoms:

- Visual symptoms, such as blind spots, flashes of light, zigzag lines, or other distortions
- Motor weakness
- Sensory symptoms, such as paresthesias
- Aphasia
- Signs of brainstem dysfunction, such as diplopia, ataxia, or vertigo

The symptoms should be fully reversible, developing over 5 to 20 minutes and lasting less than 60 minutes. The table below summarizes the IHS criteria for migraine with aura. It is commonly observed in clinical practice that not all auras are followed by a headache or a headache that is associated with characteristics of migraine. If aura occurs without subsequent headache, then the condition is a typical aura without headache; if a nonmigraine headache follows aura, then it is classified as a typical aura with a nonmigraine headache.

Table: Adapted IHS Criteria for Migraine with Typical Aura

A	At least 2 attacks fulfilling criteria B
B	Aura consisting of at least one of the following, but no motor weakness: • Fully reversible visual symptoms including positive features (e.g., flickering lights, spots, or lines) and/or negative features (i.e., loss of vision) • Fully reversible sensory symptoms including positive features (i.e., pins and needles) and/or negative features (i.e., numbness) • Fully reversible dysphasic speech disturbance
C	At least two of the following: • Homonymous visual symptoms and/or unilateral sensory symptoms

	• At least one aura symptom develops gradually 5 minutes or more and/or different aura symptoms occur in succession over 5 or more minutes
D	Headache fulfilling criteria for migraine without aura beginning during the aura or follows the aura within 60 minutes

Without Aura

Migraine without aura is characterized by head pain that is virtually indistinguishable from the pain experienced by patients with aura; the difference, as the name implies, is that in migraine without aura, no aura precedes a migraine attack. Because migraine without aura does not have a single distinguishing feature, the IHS criteria for migraine without aura require the presence of a constellation of symptoms (see table below).

Table: Adapted from IHS Criteria for Migraine without Aura*

Headache Descriptions (Any 2)	Associated Symptoms (Any 1)
• Unilateral • Pulsatile quality • Moderate to severe pain intensity • Aggravation by or causing avoidance of routine physical activity	• Nausea and/or vomiting • Photophobia and phonophobia
*Must have 5 attacks fulfilling the above criteria and no signs of a secondary headache disorder. The headaches last 4–72 hours	

Despite the existence of specific criteria, clinicians frequently misdiagnose migraine. One reason for error is the criteria themselves. The IHS criteria do not include all symptoms frequently observed in episodes of migraine. Consequently, migraine associated with muscle or neck pain, a non-IHS migraine diagnostic criterion, is often diagnosed as tension-type headache (TTH), or migraine associated with nasal symptoms such as rhinorrhea and nasal congestion, also not included as IHS diagnostic criteria, is diagnosed as a "sinus" headache. In both cases, research demonstrates that these headaches are usually migraine.

In addition, clinicians often focus on the presence of a single symptom to make a migraine diagnosis. In one study, providers who diagnosed migraine only based on the presence of unilateral head pain diagnosed 31% of patients incorrectly, and those who used vomiting as the hallmark symptom missed 50% of all cases. Similarly, many patients who present with tension headache, stress headache, and "sinus headaches" may be IHS migraineurs. A recent study of patients with self-reported sinus headaches found that 63% met IHS diagnostic criteria for migraine without aura and 33% met IHS criteria for migrainous headaches (in which patients lack one of the IHS diagnostic criteria for migraine). In other work, Stang compared the outpatient headache diagnoses of primary care physicians with the headache diagnoses of a validated algorithm. Using the validated algorithm as the gold standard, primary care physicians missed the diagnosis of migraine headache in 55% of migraine patients. Coexisting TTH in 50% of these patients was the most significant negative predictor of a diagnosis of migraine

headache. A recent study by Lipton found that the occurrence of 3 primary criteria (disability, nausea, and sensitivity to light) were highly predictive for migraine in a primary care setting. Using this combination of migraine symptoms, their 3-item ID Migraine Screener yielded a sensitivity of 0.81 (95% confidence interval [CI], 0.77 to 0.85), a specificity of 0.75 (95% CI, 0.64 to 0.84), and a positive predictive value of 93.3 (95% CI, 89.9 to 95.8). The sensitivity and specificity of these attributes is similar to other common screening tools, such as the Primary Care Evaluation of Mental Disorders (PRIME-MD) for depression or a prostate-specific antigen (PSA) test for prostate cancer.

An especially significant complicating factor in the diagnosis of migraine is the existence of comorbid illness. Migraine has been associated with a number of psychiatric and medical-neurologic illnesses. Therefore, providers should not be surprised to find an increased incidence of affective and anxiety disorders among migraine patients. Bipolar psychiatric disturbances and phobias are also noted. The incidence of stroke, epilepsy, essential tremor, mitral valve prolapse, and Raynaud's disease also are increased in migraine patients compared with their nonmigraine counterparts.

Tension-Type Headache

TTH is the most common type of primary headache. In the general population, estimates of the prevalence of episodic TTH vary widely, from 30 to 80%. The prevalence of chronic tension-type headache (CTTH) was 2% in men and 5% in women in a Danish study. Compared with migraine, the pain of TTH tends to be less severe, bilateral, nonpulsating, and not aggravated by routine physical activity. Symptoms associated with migraine attacks, such as nausea, phonophobia, or photophobia, are rarely present, but there can be symptomatic overlap. Studies have shown that 25% of TTH patients also have migraine, and 62% of migraineurs have TTH. Moreover, epidemiologic research suggests that TTH, when it coexists with migraine, might represent a segment on the continuum of the same disorder. The IHS criteria for TTH, listed in the table below, outline a range of specific characteristics that distinguish TTH from migraine.

Table: Adapted IHS Criteria for General Diagnosis of Episodic TTH*

Headache Description (Any 2)	Associated Symptoms (Any 1)
• Pressing or tightening • Mild to moderate intensity • Bilateral location • No worsening with exertion	• No nausea or vomiting • Photophobia or phonophobia (1 allowed)
*Must have had >10 previous headache episodes and no evidence of a secondary headache disorder. Episodic TTH occur <15 days/month and CTTH occur >15 days/month. CTTH also allows the presence of mild nausea	

In the 2004 IHS diagnostic criteria, episodic TTH is a condition without associated symptoms other than photophobia or phonophobia. Although this further separates migraine and tension headache, it leaves more headache presentations somewhere in between these two extremes. Much of the void is filled by a

diagnosis of "probable migraine," which represents a headache that lacks one diagnostic criterion for migraine headache.

Cluster Headache

Findings from prevalence studies of cluster headache are controversial, but one survey calculated a prevalence of 0.24% in the general population. Patients with cluster headaches generally rate the intensity of their pain as among the worst imaginable, and cluster headache may be the most severe of the primary headache disorders. Most often, cluster headache occurs once every 24 hours for 6 to 12 weeks at a time, with remission periods typically lasting 12 months. Typical age of onset for both men and women is 27 to 31 years. However, cluster headaches are one of the few headache syndromes that are more frequent in men than in women. Research shows male to female ratios that range from 5.0:1 to 6.7:1, but there is evidence that the gap may have narrowed in the 1990s. Two recent studies found sex ratios that still showed greater frequency in men, but the ratios were only 3.5:1 and 2:1. Cluster attacks have several differentiating features. Most important of these is the presence of transient autonomic symptoms. These include signs of:

- Sympathetic hypofunction, such as miosis and ptosis
- Parasympathetic hyperfunction, such as rhinorrhea and lacrimation

These associated symptoms are always unilateral and ipsilateral to the headache; systemic symptoms, such as bradycardia, hypertension, and increased gastric acid production, may also accompany an attack. Another unique feature is that cluster episodes are "side-locked" - the headaches are always on the same side, even when long intervals separate headache episodes. See the table below for the IHS criteria for cluster headache.

Table: Adapted IHS Criteria for the General Diagnosis of Cluster Headache*

Headache Description (All 4)	Autonomic Symptoms (Any 2)
• Severe headache • Unilateral • Duration of 15–180 min • Orbital, periorbital, or temporal location	• Rhinorrhea • Lacrimation • Facial sweating • Miosis • Eyelid edema • Conjunctival injection • Ptosis
*No evidence of a secondary headache disorder. Episodic cluster headaches occur for <1 year and chronic headaches occur for >1 year.	

Chronic Headache

Population-based studies suggest that 4 to 5% of the population suffer from chronic daily headache (CDH). CDH is generally defined as more than 15 days per month with headache of any kind. The IHS has recognized the diagnosis of certain chronic headache disorders, but investigators have recommended that a separate

classification for CDH be added to the IHS diagnostic criteria. The table below lists the proposed classification of CDH. The newly published IHS criteria, while not adding a separate category of CDH, recognized and added to the migraine classification the disorder of chronic migraine (see Table 1.7 in the original guideline document). Patients with chronic migraine have headaches on 15 or more days per month, and the headaches retain much of the typical characteristics of episodic migraine without aura.

Table. The Proposed Classification of Chronic Daily Headache*

Chronic migraine
Chronic tension-type headache
New daily persistent headache
Hemicrania continua
*Headaches can occur both with and without rebound headache

Chronic Tension-Type Headache

The characteristics of the head pain are similar in chronic and episodic TTH. Proposed diagnostic criteria for CTTH include more than 15 headache days per month, a history of episodic TTH, and headache characteristics similar to episodic IHS TTH. Patients may also have mild accompanying nausea and still receive a diagnosis of chronic tension type headaches, which represents a change from past criteria.

New Daily Persistent Headache

The IHS defines new daily persistent headache as headache that is daily and unremitting from very soon after onset (within 3 days at most). The pain is typically bilateral, pressing or tightening in quality, and of mild to moderate intensity. There may be photophobia, phonophobia, or mild nausea.

Hemicrania Continua

Hemicrania continua is a continuous headache, which is strictly unilateral, associated with ipsilateral autonomic symptoms (similar to cluster headache), and responsive to indomethacin. The pain must be at least intermittently severe and present for 1 month.

Diagnosis in Clinical Practice

Historically, the recognition of primary headache syndromes was based on a pattern of symptoms, such as those defined by the IHS. Yet most office-based evaluations of headache occur when patients are asymptomatic. This fact in itself rules out most urgent pathologies and allows a physician to rely on impact-based recognition of migraine. On those occasions when a person is being evaluated during a headache, it is best to rely on IHS criteria (see table below).

Table: Characteristics of Primary Headache Disorders

	Migraine	Tension-Type*	Cluster
Location	Unilateral	Bilateral	Strictly unilateral
Intensity	Moderate/severe	Mild/moderate	Severe
Duration	4 to 72 hours	30 min to 7 days	15 to 90 min
Quality	Throbbing	Pressing/tightening	Severe
Associated symptoms	Yes	No	Yes -- autonomic
Gender	Female > male	Female > male	Male > female

*Episodic

Given the constraints of clinical practice, however, primary headache disorders can be quickly and reliably recognized by asking the following 4 questions:

1. How do headaches interfere with your life?

   Recurrent headaches that produce significant disability should be considered migraine until proven otherwise. Allowing a patient to explain the impact of headaches helps define disability, establishes rapport, and directs therapeutic interventions. For example, headaches that restrict important activities such as work or home responsibilities suggest a need for aggressive therapy, whereas headaches with less impact may be adequately treated with nonprescription medications. In this way, the clinician provides the appropriate tools for managing the spectrum of headache activity that a patient is experiencing. This paves the way for patient involvement, and it allows clinicians to focus on managing patients rather than just headaches.

2. How frequently do you experience headaches of any type?

   The frequency of headaches alerts the clinician to chronic headache disorders and migraine transformation. Daily or near-daily headache patterns should alert the provider to the possibility of medication overuse. Frequent headaches raise the issue of adding a preventive medication to the patient's treatment regimen.

3. Has there been any change in your headache pattern over the last 6 months?

   An affirmative answer indicates the need for a more in depth evaluation of possible warning signs, or "red flags" (see table below), whereas a negative response reassures the physician and the patient that serious underlying disease is unlikely.

Red Flags for a Secondary Headache Disorder
• A new or different headache • "Thunderclap" headache (peak intensity within seconds to minutes) • Worst headache ever • Focal neurologic signs or symptoms, such as papilledema, motor weakness, memory loss, papillary abnormalities, or sensory loss • Change in existing headaches • New onset headache after age 50

Red Flags for a Secondary Headache Disorder
• Headache associated with systemic symptoms (fever, weight loss, jaw claudication)

4. How often and how effectively do you use medication to treat headaches?

   Generally, patients should not use acute treatment medications more than 2 days a week. This is an ideal goal and, at present, for many patients it is not possible to attain. Being pain free and fully functional within 2 to 4 hours is the goal of acute headache therapy. An inability to achieve this goal suggests the need to change medication. It is essential to query patients about prescription and nonprescription medication usage. Overuse of any acute headache remedy, prescription or nonprescription, may promote more frequent headaches. Self-management efforts can be assessed, and therapy can be modified to meet a broad spectrum of a patient's needs.

Comfort Signs

Primary headache conditions are associated with certain clinical attributes that can be identified through the clinical history. These characteristics, when present, increase diagnostic comfort (see table below). For example, when migraine seems a likely diagnosis, query about prodrome, aura, postdrome, family history, and menstruation, which correlate highly with migraine. Although many headaches will not precisely fulfill the IHS diagnostic criteria for a given diagnosis, it can be reassuring when they do. In addition, patients should have normal vital signs, physical examination, and screening neurologic examination. Any abnormalities require further evaluation. Response to a treatment plan over time supports a diagnosis of primary headache. Therefore, scheduling follow-up visits allows the physician to identify the rare secondary cause of headaches, assess treatment response, screen for comorbidities, such as depression or irritable bowel syndrome, and monitor use of medication.

Migraine Comfort Signs
• Positive family history of migraine • Headache related to menstrual cycle • Headaches preceded by typical aura • Headaches remaining periodic and stable over time • Normal physical and neurologic findings

Diagnostic Testing

Laboratory Studies

Laboratory studies, including complete blood count (CBC), blood chemistries, and urine analysis, are generally of little value for diagnosis. Baseline laboratory studies, such as a hepatic profile, may be valuable in patients who are to start pharmacologic agents that may be contraindicated in those with suspected or unsuspected liver disease (e.g., divalproex sodium). Secondary headache can

rarely be caused by endocrinopathy (pituitary tumors, thyroid disease, etc), and appropriate endocrinologic tests may be ordered if a disorder is suspected. Always assess erythrocyte sedimentation rate in patients over 50 years of age to rule out giant cell arteritis.

Neuroimaging

Neuroimaging, including computed tomography (CT) and magnetic resonance imaging/angiography (MRI/MRA) will detect most structural abnormalities that can result in headache symptoms. Magnetic resonance imaging is more sensitive for specific abnormalities of the posterior fossa and cervical/medullary pathology as well as white matter disturbances. The US Headache Consortium guidelines for neuroimaging suggest routine testing is not warranted in recurrent headache (specifically migraine) without neurologic findings, a history of seizures, or changes in headache history. Atypical headache history may also warrant neuroimaging.

Lumbar Puncture

Lumbar puncture is indicated when the following diseases are suspected:

- Viral or bacterial meningitis
- Subarachnoid hemorrhage
- Carcinomatous meningitis
- Pseudotumor cerebri
- Encephalitis
- Systemic diseases known to affect the central nervous system (i.e., sarcoidosis, lupus, vasculitis)

In the case of suspected subarachnoid hemorrhage, a noncontrast computed tomography will miss approximately 10% of bleeds; lumbar puncture is essential to rule out xanthochromia. Keep in mind that complications of lumbar puncture may include headache.

Other Tests

Electroencephalography is rarely necessary or useful in the routine evaluation of a headache patient. It may be useful in patients with headache and a seizure history, head trauma with signs of alteration of consciousness, or syncope. Thermography has not been found to be useful in the diagnosis or management of individuals with headache. Transcranial Doppler studies have also not demonstrated value in the evaluation of headache patients.

Specialist Referral

Knowing when to refer a headache patient is an important aspect of managing patients optimally in the primary care setting. The table below lists the appropriate reasons to refer a headache patient to a specialist.

Reasons to Refer Headache Patients

- Diagnostic uncertainty
- Treatment failure
- Suspicion of a secondary headache syndrome
- Rebound or chronic daily headache
- Reassurance for patient or provider

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

In addition to incorporating the US Headache Consortium's recommendations, the conclusions reflect clinical experience and the most recent medical literature.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Since head pain can have many causes, a rational approach will facilitate differential diagnosis and may increase the likelihood of a positive therapeutic outcome.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Drug therapy is constantly evolving as new research, clinical trials, case reports, and opinions are published. Many of the drugs recommended in the original guideline document are not approved by the US Food and Drug Administration (FDA) for treatment of headache, nor are they necessarily the same as those therapies recommended by the manufacturer for labeled indications. Their use in headache, however, may be supported by the scientific literature and by the authors' clinical experiences. While efforts have been made to ensure accuracy, the authors and publisher do not assume responsibility for the consistent updating of available information for the original guideline document, nor for any errors or omissions, nor for any consequences thereof. The onus is on the practitioner to evaluate recommendations in light of the clinical condition of the patient and recent medical literature. The authors advise the practitioner to consult other sources, especially the manufacturers' warnings and precautions, before

prescribing any drug with which they are unfamiliar. Practitioners are also advised that while these guidelines will address the needs of many patients, there will be circumstances calling for exceptions to these recommendations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Foreign Language Translations
Patient Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Martin V, Elkind A. Diagnosis and classification of primary headache disorders. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache Foundation; 2004. p. 4-18. [35 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004

GUIDELINE DEVELOPER(S)

National Headache Foundation - Private Nonprofit Organization

SOURCE(S) OF FUNDING

National Headache Foundation

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Authors: Vincent Martin, MD, and Arthur Elkind, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available from the National Headache Foundation, 820 N. Orleans, Suite 218, Chicago, IL 60610; Phone: (888) NHF-5552; Web address: www.headaches.org

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Headache screening questionnaire. Chicago (IL): National Headache Foundation. 2 p. Electronic copies available in Print Documentation Format (PDF) from the National Headache Foundation Web site.
- The complete headache chart. Chicago (IL): National Headache Foundation (NHF); 2 p. Electronic copies available in Portable Document Format (PDF) from the National Headache Foundation Web site
- National Headache Foundation fact sheet. Chicago (IL): National Headache Foundation (NHF); 2004 Oct. 2 p. Electronic copies available in Portable Document Format (PDF) from the National Headache Foundation Web site.

Print copies: Available from the National Headache Foundation, 820 N. Orleans, Suite 218, Chicago, IL 60610; Phone: (888) NHF-5552; Web address: www.headaches.org

PATIENT RESOURCES

The National Headache Foundation (NHF) has created a variety of educational resources for patients, including informative brochures, a patient diary for migraines, Power Point presentations, and patient guides; many of these resources are available in both Spanish and English. Some of these items are available as print copies for purchase through the NHF online store. Electronic versions of other resources are available through the consumer education section of the NHF Web site.

Print copies: Available from the National Headache Foundation, 820 N. Orleans, Suite 218, Chicago, IL 60610; Phone: (888) NHF-5552; Web address: www.headaches.org.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

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